REPORT TO THE

TWENTY-THIRD LEGISLATURE

STATE OF HAWAII

2006

PURSUANT TO
SECTION 321-195, HAWAII REVISED STATUTES,
REQUIRING A REPORT BY THE
DEPARTMENT OF HEALTH ON
IMPLEMENTATION OF THE
STATE PLAN FOR SUBSTANCE ABUSE

PREPARED BY:

ALCOHOL AND DRUG ABUSE DIVISION

DEPARTMENT OF HEALTH
STATE OF HAWAII
JANUARY 2006

EXECUTIVE SUMMARY

The annual report covering Fiscal Year 2003-04 and Fiscal Year 2004-05 for the Department of Health, Alcohol and Drug Abuse Division (ADAD) is submitted pursuant to Section 321-195, Hawaii Revised Statutes.

The agency's mission is to provide the leadership necessary for the development and delivery of quality substance abuse prevention and treatment services for Hawaii residents. ADAD plans, coordinates, provides technical assistance, and establishes mechanisms for training, data collection, research and evaluation to ensure that resources are utilized in the most effective and efficient manner possible. ADAD is the primary and often sole source of public funds for substance abuse prevention and treatment services. ADAD's efforts are designed to promote a statewide, culturally appropriate, comprehensive system of services to meet the needs of individuals and families. (Treatment services have, as a requirement, priority admission for pregnant women, injection drug users, native Hawaiians and adult offenders.)

Substance abuse prevention is a dynamic and proactive process that attempts to reduce the supply and demand for alcohol and other drugs by focusing on: the agent, which is defined as alcohol, tobacco, and other legal and illegal drugs; the host, which is defined as the individual or group, their susceptibilities to alcohol and other drug-related problems, and their knowledge and attitudes that influence their behavior; and the environment, which is defined as the setting or context in which drinking and other drug-using behavior occurs or is influenced. The challenge is to reduce the demand for alcohol and other drugs. Because the agent (drugs), the host (individual or group) and the environment (society) are interactive and interdependent, prevention efforts must deal with all three simultaneously.

Substance abuse treatment refers to the broad range of services, including identification, intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services and follow-up for persons with substance abuse problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems.

> ***Addiction*** *is a biopsychosocial disease, a distinct disorder requiring ongoing treatment and intervention, not only episodic or acute care. A person's addictive disorder cannot be addressed in isolation from addressing his or her biological, psychological or social needs. Addicted people may go on denying their alcohol and other drug problems, even when their lives are in shambles. It often takes serious trouble -- with the law, at school, at work, or in the family -- for them to make a move towards treatment. Most people think of treatment success as immediate, complete abstinence forever. Often, no provision is made for relapse, or understanding of the chronic and relapsing nature of the disease.*

Highlights of accomplishments during Fiscal Years 2003-04 and 2004-05 include:

Substance Abuse Prevention and Treatment (SAPT) Block Grant. Secured $7,201,410 and $7,233,141 in State Fiscal Years 2003-04 and 2004-05, respectively, of SAPT Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration to plan, implement and evaluate substance abuse prevention and treatment activities.

Hawaii State Incentive Grant (SIG) for Substance Abuse Prevention. The Hawaii State Incentive Grant program (funded at $8.4 million over four years) has been supporting 18 community partnerships statewide that are field testing evidence-based youth substance abuse prevention programs developed in response to local communities' analysis of their particular needs. The partnerships are implementing a total of 17 specific evidence-based interventions including school-based curricula such as the Life Skills Training Program, Positive Action, after-school programs such as the Boys and Girls Clubs of America's Smart Moves program, and programs for parents such as Solutions for Families and Families and Schools Together. The goal is to prevent and reduce youth alcohol and drug use.

Thirteen community partnerships enrolled 2,374 youth and 765 adults in prevention programs. Five additional partnerships in the communities of Molokai, Waianae, Waipahu, Kaneohe and Honokaa completed intensive community assessment and planning activities through the Communities That Care planning process to identify their local needs and resources and select evidence-based prevention programs for implementation.

(On Oahu, partnerships in Nuuanu/Makiki, Kaimuki/Palolo, Waialua/Haleiwa, Kahuku/Laie, Ewa and Kalihi served 1,486 youth and 590 parents. On the Big Island, partnerships in South Kona and North Kohala served 524 youth. On Kauai, the Waimea and Central Kauai partnerships served 181 young people. In Maui County, community partnerships in Wailuku, Lanai, and Makawao served 183 youth and 175 parents.)

Substance abuse treatment for offenders. During Fiscal Years 2003-04 and 2004-05, a total of 514 and 471 offenders, respectively, were served under the contract for integrated case management services and safe, clean and sober housing in the City and County of Honolulu and the counties of Kauai, Maui and Hawaii.

In Fiscal Year 2003-04, referrals included: 68 offenders on Kauai (21 on supervised release, 37 on probation, 1 on furlough and 9 on parole), 195 offenders on Oahu (54 on supervised release, 54 on probation and 87 on parole), 122 offenders in Maui County (24 on supervised release, 79 on probation, 8 furloughees and 11 on parole), and 129 offenders on the Big Island (9 on supervised release, 110 on probation, -0- on furlough and 10 on parole). In Fiscal Year 2004-05, referrals included: 55 offenders on Kauai (23 on supervised release, 24 on probation and 8 on parole), 181 offenders on Oahu (61 on supervised release, 53 on probation and 67 on parole), 125 offenders in Maui County (41 on supervised release, 63 on probation, 10 furloughees and 11 on parole), and 110 offenders on the Big Island (11 on supervised release, 90 on probation and 9 on parole).

Substance Abuse Prevention and Treatment Services. Through contracts with community-based substance abuse prevention and treatment agencies, ADAD provided services to adults and adolescents as follows:

A continuum of residential, outpatient, day treatment and therapeutic living services were provided to 2,200 and 2,435 adults statewide in Fiscal Years 2003-04 and 2004-05, respectively;

Residential and school-based outpatient substance abuse treatment services were provided to 1,142 and 1,416 adolescents statewide in Fiscal Years 2003-04 and 2004-05, respectively; and

Curriculum-based youth substance abuse prevention and parenting programs, mentoring programs, elderly effective medication management programs, underage drinking initiatives and Regional Alcohol and Drug Awareness Resource (RADAR) center served 63,767 and 86,921 children, youth and adults in Fiscal Years 2003-04 and 2004-05, respectively.

Provision of Contracted or Sponsored Training. In Fiscal Year 2003-04, conducted a training program that accommodated staff development opportunities for 2,247 (duplicated health care, human service, education, criminal justice and substance abuse treatment professionals through 43 training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 20,172 Continuing Education Units (CEU's) towards their professional certification and/or re-certification as Certified Substance Abuse Counselors (CSAC's). In Fiscal Year 2004-05, conducted a training program that accommodated staff development opportunities for 1453 (duplicated) healthcare, human service, criminal justice and substance abuse treatment professionals through 46 training sessions, courses, and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 10,489.5 CEU'S towards their professional certification and/or re-certification as CSAC's in the State of Hawaii.

Programmatic and Fiscal Monitoring. Through desk audits of providers' billings, reviews of audit reports and on-site monitoring, staff examined the expenditure of funds for compliance with SAPT Block Grant restrictions, State General Fund expenditure guidelines and statutory provisions regarding grants, subsidies and purchases of service. In Fiscal Year 2003-04, provided technical assistance and monitored treatment and prevention programs statewide which included desk audits and on-site reviews of the fiscal operations of 23 programs, and reviews of audit reports from 22 agencies to ensure fiscal accountability based on the Departmental Fiscal Monitoring Manual. In Fiscal Year 2004-05, provided technical assistance and monitored treatment and prevention programs statewide which included desk audits and on-site reviews of the fiscal operations of 16 programs, and reviews of audit reports from 17 agencies to ensure fiscal accountability based on the Departmental Fiscal Monitoring Manual.

Certification of Professionals and Accreditation of Programs. In Fiscal Year 2003-04, processed 208 applications, administered 98 written and 86 oral exams and certified 42

applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 467. In Fiscal Year 2004-05, processed 205 applications, administered 90 written and 82 oral exams and certified 39 applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 503.

In Fiscal Year 2003-04, conducted a total of 15 accreditation reviews and accredited 12 organizations, some of which have multiple (residential and outpatient) accreditable programs. In Fiscal Year 2004-05, conducted a total of 20 accreditation reviews and accredited 12 organizations, some of which have multiple (residential and outpatient) accreditable programs.

Prevention Information System. ADAD has implemented a web-based Minimum Data Set (MDS) to collect demographic and process information from contracted service providers. The data is used in conjunction with quarterly and year-end reports and on-site monitoring, to measure compliance with contracts and to fulfill reporting requirements.

Policy development and legislation. Prepared informational briefs and testimonies on legislation addressing substance abuse related policies in public health, human services, education, employment, housing and criminal justice systems.

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ALCOHOL AND DRUG ABUSE DIVISION

MISSION: ***To provide the leadership necessary for the development and delivery of quality substance abuse prevention, intervention and treatment services for the residents of the State of Hawaii.***

The State of Hawaii, Department of Health's (DOH) interest in programs and services to alcohol abusers dates back to 1955, when a part-time clinic was established and supported by 10 percent of the liquor license fees collected on Oahu. It became a full-time clinic in 1959 and, in 1965, was transferred to the Mental Health Division. In 1971, the Governor created and authorized the Governor's Ad Hoc Committee on Substance Abuse which became the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) authorized by Chapter 329, Hawaii Revised Statutes. The State Substance Abuse Agency was attached to the Office of the Governor until 1975 when its functions were transferred to the DOH. The Alcohol and Drug Abuse Branch (ADAB) was formally organized within the Mental Health Division in 1976. ADAB incorporated the former alcoholism clinic and the substance abuse agency.

As part of a departmental reorganization in 1989, three divisions were established and assigned to a newly-established administration headed by the Deputy Director for Behavioral Health Services. The three divisions, two of which were formerly branches subsumed within the Mental Health Division, are now the Adult Mental Health Division, the Alcohol and Drug Abuse Division and the Child and Adolescent Mental Health Division.

The responsibilities of the DOH with respect to substance abuse are delineated under Section 321-193, Hawaii Revised Statutes.

ALCOHOL AND DRUG ABUSE DIVISION

ADAD's primary functions include:

GRANTS AND CONTRACTS MANAGEMENT

CLINICAL CONSULTATION

QUALITY ASSURANCE:

- **TRAINING**
- **ACCREDITATION OF SUBSTANCE ABUSE TREATMENT PROGRAMS**
- **CERTIFICATION OF SUBSTANCE ABUSE COUNSELORS AND PROGRAM ADMINISTRATORS**
- **PREVENTION ACTIVITIES**

POLICY DEVELOPMENT

PLANNING

COORDINATION

INFORMATION SYSTEMS:

- **TREATMENT CLIENT DATA SYSTEM**
- **PREVENTION MINIMUM DATA SET**
- **NEEDS ASSESSMENTS FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICE**

HIGHLIGHTS OF ACCOMPLISHMENTS AND ACTIVITIES
July 1, 2003 to June 30, 2005

Grants and Contracts

Substance Abuse Prevention and Treatment (SAPT) Block Grant. Secured $7,201,410 and $7,233,141 in State Fiscal Years 2003-04 and 2004-05, respectively, of SAPT Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration to plan, implement and evaluate substance abuse prevention and treatment activities.

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Studies and Surveys

Hawaii tobacco sales to minors among lowest in the nation. According to the 2004 survey by the State Department of Health's (DOH), Alcohol and Drug Abuse Division (ADAD), sales of tobacco to minors in Hawaii decreased compared to last year. The survey is a joint effort between DOH and the University of Hawaii's Cancer Research Center of Hawaii.

In the Spring of 2004, teams made up of youth volunteers (ages 15-17) and adult observers visited a random sample of 211 stores in which the youth attempted to buy cigarettes to determine how well retailers were complying with the State tobacco laws. Eleven stores (5.2%) sold to minors (ages 15-17) without identification. Since this annual survey started in 1996, the rates of noncompliance have dropped from 44.5% (1996) to 6.2% in 2003 and finally to 5.2% this year.

The Hawaii Year 2004 survey found that 5.2% of the stores inspected, in the scientifically-based random sample of retail outlets throughout the State, sold cigarettes to minors. The 2004 non-compliance rate for the City and County of Honolulu is 6.3%. Hawaii and Kauai County rates of sales are 0.0%, while the Maui County rate is 6.9%.

The significant factors associated with purchase of tobacco during 2004 annual inspections were:

> *Type of outlet*. Gas stations and gas convenience stores were more likely to sell to minors (14.0% compared to 6.6% for grocery, food, restaurant and liquor stores).
>
> *Whether the clerk requested identification*. 50% of clerks who did not ask the minor for identification sold tobacco to minors.
>
> *Whether the clerk requested identification or age*. If clerks did not ask for age or identification, they were ten times more likely to sell to minors.
>
> *Gender of minor*. Clerks were more likely to sell to male minors (19.1%) than to female minors (1.8%).
>
> *Age of minor*. Clerks sold to minors 15 years old more frequently (15.4%) than to minors age 16 (2.8%) or age 17 (9.4%).

Hawaii State Law prohibits tobacco sales to persons under the age of 18. Merchants

convicted of selling to minors face a mandatory fine of $500.

The DOH provides information and training to educate store clerks to help them identify minors and develop skills to prevent sales to those under the age of 18. Newly developed outreach materials help clerks know which years on identification documents they can sell tobacco products to. Statewide compliance inspections, in partnership with the Cancer Research Center and the County Police Departments, will continue to be conducted.

Hawaii has a comprehensive tobacco prevention strategy with an aggressive, engaging media campaign, extensive merchant education, and a print campaign that recognizes local merchants who complied and did not comply with the illegal sales to minors law.

In addition to the Synar Regulation inspections, the DOH, in cooperation with all four County Police Departments and the Cancer Research Center of Hawaii, has a program to enforce the State statute. Every outlet in the State that sells tobacco is inspected at least once a year, and often twice. The enforcement program uses teenagers between the ages of 15 and 17, carrying identification, who attempt to purchase cigarettes under the supervision of an undercover police officer. (The Synar Regulation, a federal mandate, requires each state to document a rate of tobacco sales to minors of no more than 20% or risk losing federal funds for alcohol and other drug abuse prevention and treatment services.)

There were 1,136 retail outlets throughout the State of Hawaii inspected from April 1, 2003 to March 31, 2004. 15.9% of the outlets (180 stores) sold to minors (ages 15-17) who produced valid identification if asked for it. This is a slight increase from last year's noncompliance rate of 13.9% (2003). Results of these operations were published monthly in all county newspapers.

Provision of Contracted or Sponsored Training

In Fiscal Year 2003-04, conducted a training program that accommodated staff development opportunities for 2,247 (duplicated health care, human service, education, criminal justice and substance abuse treatment professionals through 43 training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 20,172 Continuing Education Units (CEU's) towards their professional certification and/or re-certification as Certified Substance Abuse Counselors (CSAC's). In Fiscal Year 2004-05, conducted a training program that accommodated staff development opportunities for 1453 (duplicated) healthcare, human service, criminal justice and substance abuse treatment professionals through 46 training sessions, courses, and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults. Participants earned 10,489.5 CEU'S towards their professional certification and/or re-certification as CSAC's in the State of Hawaii.

Topics covered during the reporting period include, but are not limited to: motivational interviewing, confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), Health Insurance Portability and Accountability Act of 1996 (HIPAA), CSAC application

and examination processes, Code of Ethics for Certified Substance Abuse Counselors, tobacco prevention, American Society of Addiction Medicine Patient Placement Criteria II (Revised), Addiction Severity Index (ASI), and fetal alcohol syndrome.

Programmatic and Fiscal Monitoring and Request for Proposal (RFP) Process

A total of $18.4 million and $27.2 million in Fiscal Year 2003-04 and Fiscal Year 2004-05, respectively, in State General Funds, federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds and categorical federal grants was expended through contracts with nonprofit organizations providing substance abuse prevention and treatment services.

Through desk audits of providers' billings, reviews of audit reports and on-site monitoring, staff examined the expenditure of funds for compliance with SAPT Block Grant restrictions, State General Fund expenditure guidelines and statutory provisions regarding grants, subsidies and purchases of service. In Fiscal Year 2003-04, provided technical assistance and monitored treatment and prevention programs statewide which included desk audits and on-site reviews of the fiscal operations of 23 programs, and reviews of audit reports from 22 agencies to ensure fiscal accountability based on the Departmental Fiscal Monitoring Manual. In Fiscal Year 2004-05, provided technical assistance and monitored treatment and prevention programs statewide which included desk audits and on-site reviews of the fiscal operations of 16 programs, and reviews of audit reports from 17 agencies to ensure fiscal accountability based on the Departmental Fiscal Monitoring Manual.

Conducted on-site reviews of the programmatic operations of treatment and prevention agencies statewide and reviewed monthly, quarterly and year-end financial and program reports to ensure compliance with contract requirements for the delivery of services.

Certification of Professionals and Accreditation of Programs

In Fiscal Year 2003-04, processed 208 applications, administered 98 written and 86 oral exams and certified 42 applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 467. In Fiscal Year 2004-05, processed 205 applications, administered 90 written and 82 oral exams and certified 39 applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 503.

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Prevention Information System

ADAD has implemented a web-based Minimum Data Set (MDS) to collect demographic and process information from contracted service providers. The data is used in conjunction with

quarterly and year-end reports and on-site monitoring, to measure compliance with contracts and to fulfill reporting requirements.

Legislation

Legislation passed during the 2004 and 2005 Legislative Sessions that address substance abuse prevention and/or treatment related issues included:

Act 40, Session Laws of Hawaii 2004 (House Bill 2004, HD1 SD1 CD1). Appropriates funds to the Department of Health for: adolescent substance abuse treatment programs ($3,000,000), with priority given to establishing school-based treatment programs in all high schools, and in middle and intermediate schools with the greatest need for such services, and adolescent residential treatment programs; substance abuse prevention ($2,000,000), with priority given to drug education and awareness in the schools and community partnerships, non-school youth activities in communities with the greatest need, education and support for families and parenting women, and community mobilization; adult substance abuse treatment services ($4,000,000), including family counseling, with priority for women of child-bearing age, pregnant women, parents of young children in the home, and Hawaiians as defined in Section 10-2, Hawaii Revised Statutes; and three full-time equivalent positions ($200,000) in the Alcohol and Drug Abuse Division to collect data and evaluate outcomes, and for a needs assessment for adult substance abuse services or the implementation of the substance abuse treatment monitoring program.

Act 44, Session Laws of Hawaii 2004 (House Bill 2003, HD1 SD1). Adds and amends laws relating to criminal conduct for drug-related offenses; amends laws relating to first time nonviolent drug offender diversion to substance abuse treatment; adds tort liability for drug dealers; amends the zero tolerance policy for public school students who are charged with drug offenses; amends existing law to provide parity in health insurance benefits for substance abuse; adds new law on civil commitment for substance abuse outpatient treatment; adds new laws to facilitate the development of drug rehabilitation homes for recovering addicts; adds responsibility for methamphetamine removal to the Department of Health; amends the nuisance abatement laws to permit citizen's to recover attorneys' fees and to be protected in the same way as victims of crimes are protected; and amends the duties of the Department of Public Safety to include coordination of the drug abatement efforts between public, private and community organizations.

Act 152, Session Laws of Hawaii 2004 (Senate Bill 2748, SD1 HD1 CD1). Amends Act 205, Session Laws of Hawaii 1995, as amended by Act 7, SLH 1996, as amended by Act 152, SLH 1998, as amended by Act 116, SLH 2001, relating to drug demand reduction assessments special fund. Provides that any person who is convicted of an offense related to drugs and intoxicating compounds, negligent homicide in the 1st degree, felony or misdemeanor offenses involving substance abuse, consuming or possessing intoxicating liquor while operating or a passenger in a motor vehicle, storage of opened containers containing intoxicating liquor, or consumption of intoxicating liquor at a scenic lookout shall pay a monetary assessment. Provides that if the person undergoes a substance abuse treatment program at the person's expense, the court may waive or reduce the amount of the

monetary assessment. Provides that upon a showing by the defendant that the defendant is or will be unable to pay the monetary assessment during the period of the defendant's sentence, the court may decline to order the defendant to pay the monetary assessment.

Act 213, Session Laws of Hawaii 2005 (Senate Bill 1816, SD2 HD1 CD1). Section 2 of Act 213, SLH 2005, replaced Act 44, SLH 2004, amendments to Section 302A-1134.6, HRS. The Student Substance Abuse Assessment and Treatment Advisory Task Force was created pursuant to Section 3 of Act 213, SLH 2005, to review the implementation of Section 302A-1134.6, HRS. The Task Force is charged with reviewing the process by which a student who violates the zero tolerance policy for drugs and alcohol in public schools is referred for substance abuse assessment and treatment.

S.C.R. 197, SD1. Requesting the Director of Health to Convene a Medical Marijuana Working Group to Make Recommendations to Improve Hawaii's Medical Marijuana Program.

Provision of Contracted Substance Abuse Prevention and Treatment Services

Substance Abuse Prevention and Treatment Services. Through contracts with community-based substance abuse prevention and treatment agencies, ADAD provided services to adults and adolescents as follows:

A continuum of residential, outpatient, day treatment and therapeutic living services were provided to 2,200 and 2,435 adults statewide in Fiscal Years 2003-04 and 2004-05, respectively;

Residential and school-based outpatient substance abuse treatment services were provided to 1,142 and 1,416 adolescents statewide in Fiscal Years 2003-04 and 2004-05, respectively; and

Curriculum-based youth substance abuse prevention and parenting programs, mentoring programs, elderly effective medication management programs, underage drinking initiatives and Regional Alcohol and Drug Awareness Resource (RADAR) center served 63,767 and 86,921 children, youth and adults in Fiscal Years 2003-04 and 2004-05, respectively.

ALCOHOL AND DRUG ABUSE DIVISION - INFORMATION

- Demographic Data (Adult and Adolescent Services)
- Performance Outcomes (Adults and Adolescents)
- Estimated Treatment Needs (Adults and Adolescents)
- Methamphetamine Admissions

ADAD-FUNDED ADULT SERVICES
FISCAL YEARS 2003-04 & 2004-05

ADAD-FUNDED ADULT ADMISSIONS BY GENDER

	FY 2003-04	FY 2004-05
Male	67.0%	69.0%
Female	33.0%	31.0%
TOTAL	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY ETHNICITY

	FY 2003-04	FY 2004-05
Hawaiian	43.2%	40.6%
Caucasian	25.4%	26.0%
Filipino	5.6%	7.2%
Mixed – Not Hawaiian	6.7%	6.2%
Hispanic	5.6%	5.3%
Japanese	4.6%	4.3%
Samoan	1.1%	1.3%
Black	2.0%	3.4%
Portuguese	1.5%	2.5%
Other	4.3%	3.2%
TOTAL	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2003-04	FY 2004-05
Methamphetamine	50.2%	50.0%
Alcohol	24.4%	26.4%
Marijuana	11.2%	9.4%
Cocaine/Crack	6.0%	4.8%
Heroin	3.3%	3.3%
Other	4.9%	6.1%
TOTAL	100.0%	100.0%

ADAD-FUNDED ADULT ADMISSIONS BY RESIDENCY

	FY 2003-04	FY 2004-05
Oahu	48.0%	51.0%
Hawaii	33.0%	34.0%
Maui	9.0%	8.0%
Molokai/Lanai	2.0%	2.0%
Kauai	8.0%	5.0%
TOTAL	100.0%	100.0%

ADAD-FUNDED ADOLESCENT SERVICES
FISCAL YEARS 2003-04 & 2004-05

ADAD-FUNDED ADOLESCENT ADMISSIONS BY GENDER

	FY 2003-04	FY 2004-05
Male	55.0%	53.0%
Female	45.0%	47.0%
TOTAL	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY ETHNICITY

	FY 2003-04	FY 2004-05
Hawaiian	55.9%	56.3%
Caucasian	11.1%	11.4%
Filipino	8.5%	8.1%
Mixed – Not Hawaiian	8.5%	6.9%
Hispanic	3.7%	3.2%
Japanese	3.4%	4.3%
Samoan	4.3%	3.0%
Black	0.6%	1.0%
Portuguese	1.0%	1.3%
Other	3.0%	4.5%
TOTAL	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY PRIMARY SUBSTANCE

	FY 2003-04	FY 2004-05
Methamphetamine	5.5%	5.1%
Alcohol	31.8%	35.1%
Marijuana	60.1%	54.7%
Cocaine/Crack	0.7%	0.6%
Heroin	0.1%	-0-
Other	1.8%	4.5%
TOTAL	100.0%	100.0%

ADAD-FUNDED ADOLESCENT ADMISSIONS BY RESIDENCY

	FY 2003-04	FY 2004-05
Oahu	68.0%	61.0%
Hawaii	8.0%	19.0%
Maui	15.0%	12.0%
Molokai/Lanai	1.0%	1.0%
Kauai	8.0%	7.0%
TOTAL	100.0%	100.0%

PERFORMANCE OUTCOMES
ADOLESCENT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2004 and 2005 (July 1, 2003 to June 30, 2004 and July 1, 2004 to June 30, 2005), six-month follow-ups were completed for samples of 274 and 320 adolescents, respectively. Listed below are the outcomes for these samples.

MEASURE	PERFORMANCE OUTCOME ACHIEVED	
	FY 2004	FY 2005
Employment/School/Vocational Training	92.7%	92.8%
No arrests since discharge	79.6%	80.3%
No substance use in 30 days prior to follow-up	51.5%	53.7%
No new substance abuse treatment	71.2%	74.7%
No hospitalizations	89.8%	90.0%
No emergency room visits	89.1%	89.4%
No psychological distress since discharge	72.3%	74.1%
Stable living arrangements	91.2%	92.5%

PERFORMANCE OUTCOMES
ADULT SUBSTANCE ABUSE TREATMENT

During State Fiscal Years 2004 and 2005 (July 1, 2003 to June 30, 2004 and July 1, 2004 to June 30, 2005), six-month follow-ups were completed for samples of 1,430 and 1,706 adults, respectively. Listed below are the outcomes for these samples.

MEASURE	PERFORMANCE OUTCOME ACHIEVED	
	FY 2004	FY 2005
Employment/School/Vocational Training	39.8%	46.6%
No arrests since discharge	79.4%	76.1%
No substance use in 30 days prior to follow-up	65.1%	65.9%
No new substance abuse treatment	69.1%	65.4%
No hospitalizations	83.9%	79.7%
No emergency room visits	81.5%	77.8%
Participated in self-help group (NA, AA, etc.)	46.4%	45.1%
No psychological distress since discharge	72.6%	66.5%
Stable living arrangements	86.4%	88.9%

1998 ESTIMATED NEED*
FOR ADULT ALCOHOL AND DRUG ABUSE
TREATMENT IN HAWAII

ESTIMATE OF DEPENDENCE AND ABUSE (NEEDING TREATMENT)					
	COUNTY				
	HONOLULU	MAUI	KAUAI	HAWAII	TOTAL
Population (18 Years and Over)	668,524	85,645	41,304	99,941	895,414
NEEDING TREATMENT					
Alcohol Only	49,285	7,496	2,463	9,682	68,926
Drugs Only	3,476	1,679	483	1,509	7,074
Alcohol and/or Drugs	57,623	9,822	3,259	12,176	82,880

Source: "Hawaii 1998 Adult Telephone Household Survey of Substance Use" prepared by the University of Hawaii at Manoa School of Public Health for the Department of Health - Alcohol and Drug Abuse Division. (Based on 1990 U.S. Census Data and 1998 estimates.)

Findings of the 1998 Adult Telephone Household Survey reveal that of the state's total 895,414 adult population over the age of 18, a total of 82,880 (9.3%) are in need of treatment for alcohol and/or other drugs. Comparable figures by county are as follows:

For the **City and County of Honolulu**, 57,623 (8.6%) of the total 668,524 adults on Oahu are in need of treatment for alcohol and/or other drugs. Of the 57,623 adults in need of treatment, 28,615 (49.7%) were males and 29,008 (50.3%) were females.

For **Maui County**, 9,822 (11.5%) of the 85,645 adults on Maui, Lanai and Molokai are in need of treatment for alcohol and/or other drugs. Of the total of 9,822 adults in need of treatment, 5,308 (54.0%) were males and 4,514 (46.0%) were females.

For **Kauai County**, 3,259 (7.9%) of the total 41,304 adults on Kauai are in need of treatment for alcohol and/or other drugs. Of the total 3,259 adults in need of treatment, 1,815 (55.7%) were males and 1,444 (44.3%) were females.

For **Hawaii County**, 12,176 (12.2%) of the total 99,941 adults on the Big Island are in need of treatment for alcohol and/or other drugs. Of the total 12,176 adults in need of treatment, 7,368 (60.5%) were males and 4,806 (39.5%) were females.

*Note: 2003 survey results are pending.

2003 ESTIMATED NEED*
FOR ADOLESCENT (GRADES 6-12)
ALCOHOL AND DRUG ABUSE TREATMENT
IN HAWAII

COUNTY/DISTRICT INFORMATION		Need Treatment for Alcohol Abuse		Need Treatment for Drug Abuse		Need Treatment for Both Alcohol and Drug Abuse		TOTAL TREATMENT NEEDS	
	Total N	%	N	%	n	%	n	%	n
HONOLULU	61,096	2.0%	1,203	1.8%	1,073	2.4%	1,493	6.2%	3,759
Honolulu District	16,542	1.7%	289	1.4%	238	2.3%	378	5.5%	902
Central District	16,046	1.8%	291	2.0%	324	1.9%	309	5.7%	922
Leeward District	19,921	2.0%	399	1.7%	347	2.3%	467	6.1%	1,208
Windward District	8,587	2.6%	224	1.9%	164	4.0%	339	8.5%	727
Hawaii County/District	12,734	3.5%	450	2.2%	275	4.7%	602	10.4%	1,330
Kauai County/District	5,632	1.6%	88	1.9%	104	3.5%	199	7.0%	392
Maui County/District	10,976	3.0%	326	2.7%	301	3.8%	419	9.5%	1,044
All Public Schools	90,438	2.3%	2,067	1.9%	1,753	3.0%	2,713	7.2%	6,525
Private Schools	22,871	1.9%	433	0.9%	208	2.9%	660	5.7%	1,301
TOTAL STATEWIDE	113,309	2.2%	2,500	1.7%	1,961	3.0%	3,373	6.9%	7,826

*Notes: A substance abuse/dependency diagnosis is calculated based on the student's response to items that correspond with the DSM-III-R criteria, which assess a variety of negative consequences related to substance use. Students responded to abuse and dependency questions for each of the following substances: alcohol, marijuana, stimulants (cocaine, methamphetamine, speed), depressants or downers (sedatives, heroin), hallucinogens, and club drugs (ecstasy, GHB, Rohypnol, ketamine).

Substance abuse is indicated by at least one of the following:

(1) Continued use of the substance despite knowledge of having a persistent or recurrent problem(s) at school, home, work, or with friends because of the substance, or
(2) Substance use in situations in which use is physically hazardous (e.g., drinking or using drugs when involved in activities that could have increased the student's chance of getting hurt).

For the student to be classified as abusing a substance, at least one of the two abuse symptoms must have occurred more than once in a single month or several times within the last year. In addition, the student must not meet the criteria for dependency on that substance.

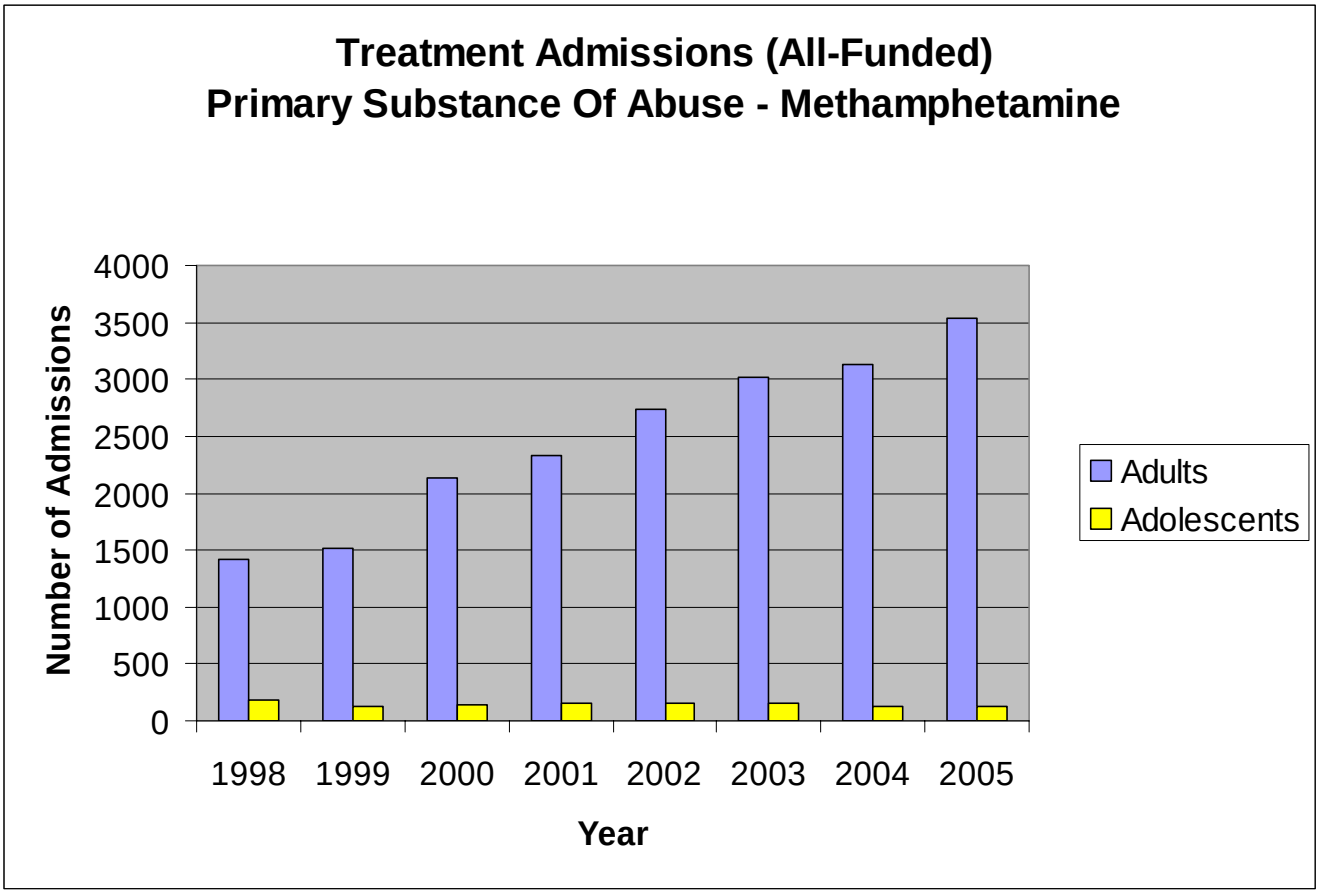
For the student to be classified as abusing a substance, at least one of the two abuse symptoms must have occurred more than once in a single month or several times within the last year. In addition, the student must *not* meet the criteria for dependency on that substance.

Substance dependency is the most severe diagnosis. Substance dependency is indicated by the student's response to nine different diagnostic criteria for dependency (e.g., marked tolerance, withdrawal symptoms, use of substances to relieve/avoid withdrawal symptoms, persistent desire or effort to stop use, using more than intended, neglect of activities, great deal of time spent using or obtaining the substance, inability to fulfill roles, drinking or using substances despite having problems). A student is considered dependent on the substance if he/she marked "yes" to at least three DSM-III-R symptoms and if he/she indicated that at least two of the symptoms occurred several times. The abuse estimates above include students who *either* abuse or are dependent on a particular substance. Only public school students are included in the county and district estimates.

Next survey update is scheduled for 2006.

METHAMPHETAMINE ADMISSIONS
1998-2005

The increase in crystal methamphetamine use is reflected in the increase of adult crystal methamphetamine admissions to treatment since 1998 as illustrated by the graph and table below.



	1998	1999	2000	2001	2002	2003	2004	2005
Adults	1,423	1,517	2,136	2,332	2,730	3,013	3,136	3,538
Adolescents	189	126	143	150	158	150	129	120
Total	1,612	1,643	2,279	2,482	2,888	3,163	3,265	3,658

SUBSTANCE ABUSE TREATMENT INFORMATION

- Addiction
- Trends and Issues that Impact Alcohol and Drug Problems
- Treatment Priority Populations
- What Happens in Treatment
- Principles of Effective Treatment
- Treatment Programs that Work
- Substance Abuse Treatment Goals (2004-2008)
- Substance Abuse Treatment Monitoring Program

ADDICTION

The Diagnostic and Statistical Manual - IV (DSM-IV) describes addiction as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

Substance is often taken in larger amounts or over longer period than intended.

Persistent desire or unsuccessful efforts to cut down or control substance use.

A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects.

Addiction is a biopsychosocial disease, a distinct disorder requiring ongoing treatment and intervention, not only episodic or acute care. A person's addictive disorder cannot be addressed in isolation from addressing his or her biological, psychological or social needs.

Important social, occupational, or recreational activities given up or reduced because of substance abuse.

Continued substance use despite knowledge of having a persistent or recurrent psychological or physical problem that is caused or exacerbated by use of the substance.

Tolerance, as defined by either:

Need for markedly increased amounts of the substance in order to achieve intoxication or desired effect; or

Markedly diminished effect with continued use of the same amount.

Withdrawal, as manifested by either:

Characteristic withdrawal syndrome for the substance; or

The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

TRENDS AND ISSUES THAT IMPACT ALCOHOL AND DRUG PROBLEMS

Linkages with substance abuse prevention and treatment services in Federal, State and local level initiatives in health care, criminal justice and welfare reform reflect a growing awareness of the extent to which substance abuse impacts the individual, the family and the community.

Strengthening core services and enhancing the continuum of substance abuse services available throughout the State will improve the accessibility, quality and availability of services.

Socio-economic conditions that alter accustomed living patterns.

Shortage of trained substance abuse professionals and paraprofessionals.

Fiscal constraints at both the State and Federal levels.

Availability of drugs, including cocaine, marijuana, crystal methamphetamine and heroin.

Number of drug and alcohol exposed infants.

Risk of HIV, TB, Hepatitis B and Hepatitis C infection among substance abusing populations.

Increased focus on accountability and outcome objective monitoring and evaluation.

The Federal role and influence in setting substance abuse policy direction.

Shorter lengths of treatment duration with advent of managed care.

Increased prevalence of adolescent substance abuse.

Lack of "treatment on demand" for the public client.

Increased prevalence of substance abuse among the child welfare population.

Linkage between substance abuse treatment and components within the criminal justice system.

Multi-diagnosed clients.

Lack of sufficient residential treatment capacity for chronic public clients.

Uniqueness of public sector client needs.

Retention of alcohol and other drug abuse treatment and prevention as a basic health care benefit.

WHAT HAPPENS IN TREATMENT?

Certain elements are basic to substance abuse treatment:

Detoxification. The process of getting alcohol and/or drugs out of the system -- of getting "clean." Some people need medical help and counseling to go through "detox."

Assessment. No two substance abusers are alike in substance abuse histories or their related problems. At the start of the treatment process, these aspects of the client's life need to be evaluated to determine the best course of treatment.

During assessment, the client's substance abuse behaviors are reviewed, as are current and previous medical and psychological conditions. Other factors, such as family relations and job history, are also explored.

Treatment plan. Information gathered during assessment helps program staff work with incoming clients to develop an individualized treatment plan. The plan is like a contract -- it spells out treatment objectives, the recommended therapeutic services, and other activities. The plan includes the client's responsibilities, the program's responsibilities, and how progress will be measured.

Therapeutic activities and services. Treatment programs often address all parts of a person's life that have been disrupted by alcohol and other drugs:

Clients diagnosed with substance abuse related health and nutritional problems receive or are referred to medical care, voluntary HIV testing and education, and Tuberculosis and Hepatitis B testing.

Counseling services help clients look at the patterns of their substance abuse. In *individual therapy*, they look at the underlying causes of their addiction. In *group therapy*, among other recovering people, clients are encouraged to confront their destructive behaviors and to explore new ways of dealing with people, with emotions, and with the craving for substances. *Family counseling* helps family members understand and participate in the recovery process.

Essential to recovery is learning how to spend leisure time. Through *recreational activities* clients are introduced to alcohol- and drug-free ways of enjoying themselves and contributing to the community.

Programs may provide services to meet specific clients' needs: *classroom instruction* for students; literacy, remedial reading and math for clients who lack *basic skills*; *job training* for unemployed or underemployed adults; and assistance in finding *housing* for clients without a home.

Aftercare/Continuing Care. Aftercare is critical for a successful return to the community. It helps people continue to apply the lessons learned in treatment to their own lives:

Before clients leave treatment, they are usually introduced to outside peer support groups like Narcotics Anonymous (NA) or Cocaine Anonymous (CA), which function like Alcoholics Anonymous (AA). These groups contribute to aftercare by allowing clients to maintain relationships with other recovering people who can help them stay alcohol- and drug-free. In addition, recovering people may return to the therapeutic program for regular group and individual counseling sessions. These aftercare services help people avoid relapse.

TREATMENT PRIORITY POPULATIONS

PREGNANT AND PARENTING WOMEN AND CHILDREN

INJECTION DRUG USERS

NATIVE HAWAIIANS

ADULT OFFENDERS

PRINCIPLES OF EFFECTIVE TREATMENT*

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine

* National Institute on Drug Abuse, *Principles of Drug Addiction Treatment,* 1999.

replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

10. **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

11. **Possible drug use during treatment must be monitored continuously.** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. `Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

TREATMENT PROGRAMS THAT WORK:

- **ARE AT LEAST THREE MONTHS TO A YEAR IN DURATION.**

- **ARE INTENSIVE, COMPREHENSIVE AND HIGHLY STRUCTURED.**

- **REQUIRE THERAPY FOCUSING ON ALL ASPECTS OF THE PATIENT'S LIFE.**

- **INCLUDE PARTICIPATION IN SUPPORT GROUPS.**

- **PROVIDE ACCESS TO EDUCATIONAL, VOCATIONAL AND EMPLOYMENT OPPORTUNITIES.**

- **FOSTER A SENSE OF BELONGING TO A COMMUNITY.**

Source: Institute of Medicine Report (1990).

SUBSTANCE ABUSE TREATMENT GOALS (2004-2008)

ADOLESCENT SUBSTANCE ABUSE TREATMENT	Reduce the harm and restore life functioning for substance abusing and substance dependent adolescents by providing treatment services for substance abusing adolescents and their families.
ADULT DETOXIFICATION AND FOLLOW THROUGH PROGRAMS	Assure availability of a safe, controlled environment to assist chemically intoxicated individuals to withdraw from the physiological effects of alcohol and other drugs.
ADULT SUBSTANCE ABUSE TREATMENT	Reduce the harm and restore life functioning for substance abusing and substance dependent adults by providing substance abuse treatment and support services for substance abusing adults and their families.
PREGNANT AND PARENTING WOMEN AND CHILDREN	Reduce the impact of substance abuse on children and families by assuring availability of and access to appropriate treatment services for substance abusing women and their children.
INJECTION DRUG USERS	Reduce the spread of AIDS and other communicable diseases in the high risk substance abusing population by providing treatment for injection drug users.
MENTALLY ILL SUBSTANCE ABUSERS	Assure that substance abusers who also have a mental health problem are identified, supported and receive appropriate care.
RECOVERY GROUP HOMES	Support continuing recovery for substance abusers by assuring access to alcohol and drug free housing.

SUBSTANCE ABUSE TREATMENT MONITORING PROGRAM

The Substance Abuse Treatment Monitoring Program[1] requires the Department of Health, the Office of Youth Services, the Department of Public Safety, and the Judiciary to collect data from private providers of substance abuse treatment services that receive public funds, and state agencies that provide direct treatment services. Treatment providers are required to report admission and discharge data, as determined by the Department of Health.[2]

To accomplish the assigned tasks, agency representatives are convened in on-going semi-monthly meetings.[3] Although the enabling legislation did not specifically assign the Department of the Attorney General and the Judiciary Family Court, they have been included as part of this interagency effort.

Subcommittees have been formed to focus on services that are provided to adult and adolescent populations. Each subcommittee is focusing on core issues: differences among agencies in the data they collect, confidentiality issues, treatment outcome measures monitoring and oversight (coordination and improved efficiencies) and rate setting. Subcommittees are composed of adult- and adolescent-related agencies as listed below:

Subcommittee on Adults	Subcommittee on Adolescents
Department of Health, Alcohol and Drug Abuse Division	Department of Health, Alcohol and Drug Abuse Division
Department of Public Safety	Office of Youth Services
Hawaii Paroling Authority	Judiciary, Family Court
Judiciary, Adult Client Services	Department of Health, Child and Adolescent Mental Health Services Division
Department of the Attorney General, Crime Prevention and Justice Assistance Division	

Each of the subcommittees is tasked with reviewing:

Programs and services for their respective target populations.
State and Federal funding sources.
Funding period(s) for the source(s) of funds.
Eligibility requirements for program participation.

ADAD collects data on clients admitted to publicly-funded substance abuse treatment programs. As stipulated in agreements, providers are required to submit client data forms for both ADAD-funded and non-ADAD funded admissions. To ensure consistency in data collection, analysis

[1] Established under Part III (Sections 23-28) of Act 40, SLH 2004.
[2] Act 40, Session Laws of Hawaii (SLH) 2004, and Act 178, SLH 2005, appropriated funds to implement the Substance Abuse Treatment Monitoring Program.
[3] August 23rd , September 9th and 22nd ; October 6th and 25th , November 7th and 21st 2005.

and reporting, the working group began by submitting data elements and definitions collected at admission, discharge and follow-up:

Data elements. Data elements collected – age, race, ethnicity, employment status, source of payment, source of referral to treatment, length of treatment, and the primary substance for which treatment was sought – by each of the participating agencies and definitions used for each of the elements.

Data collection. Admission, discharge and follow-up data collected by agencies and changes needed to participating State agencies' data collection and reporting systems.

To ensure that data analysis can be accomplished within the reporting systems to be employed by agencies, working group members provided the following information on the substance abuse treatment services they provide or procure:

Substance abuse treatment services and/or programs provided or contracted.

Continuum of services and definitions for the various substance abuse treatment modalities (i.e., residential, intensive outpatient, outpatient, therapeutic living program, etc.) for the population served.

Funding sources and admission, discharge and follow-up data collected for agencies' provision or procurement of substance abuse treatment services.

As information submitted is analyzed, agency representatives will be working toward the following goals:

On-going refinement of data collection and analysis of substance abuse treatment information.

Implementation and refinement of a standardized, coordinated contract monitoring and oversight system and protocol.

Improved efficiencies in monitoring through public agencies' coordination of program monitoring activities. (The State Procurement Office will be a participant in coordinating agencies' contract monitoring efforts.)

Implementation and refinement of a standardized, coordinated evaluation process to address quality assurance issues, including a core set of treatment outcomes.

Examining current rates paid for services and the identification of effective methods to establish, assess and adjust rates on the basis of such factors as lengths of stay, model service configurations and workforce development.

SUBSTANCE ABUSE PREVENTION INFORMATION

- Substance Abuse Prevention
- Strategic Prevention Framework
- Risk and Protective Factors Related to Substance Use
- Substance Abuse Prevention – Guiding Principles and Best Practices
- Prevention Goals (2004-2008)

SUBSTANCE ABUSE PREVENTION

Substance abuse prevention is:

- ***The promotion of constructive lifestyles and norms that discourage drug use.***

- ***The development of social and physical environments that facilitate drug-free lifestyles.***

Prevention is achieved through the application of multiple strategies; it is an ongoing process that must relate to each emerging generation.

Prevention programs should:

Enhance "protective factors" and reduce known "risk factors."

Target all forms of drug abuse, including the use of alcohol, tobacco and other drugs.

Be adapted to address the specific nature of the drug abuse problem in the local community.

Include skills to resist drugs when offered.

Strengthen personal commitments against drug use.

Increase social competency -- communications, peer relationships, self-efficacy and assertiveness -- to reinforce attitudes against drug use.

Include interactive methods, such as peer discussion groups.

Include a parents' or caregivers' component that reinforces what the children are learning and creating opportunities for family discussions about use of legal and illegal substances and family policies about their use.

Span the school – elementary, middle and high school -- career with repeat interventions to reinforce the original prevention goals.

Be age-specific, developmentally appropriate and culturally sensitive.

Be cost-effective; every dollar spent on drug use prevention can save communities 4 to 5 dollars in costs for drug abuse treatment and counseling.

NIDA (April 2, 1997)

STRATEGIC PREVENTION FRAMEWORK*

The Strategic Prevention Framework provides an effective prevention process, a direction and a common set of goals, expectations and accountabilities to be adopted and integrated at all levels of endeavor. The Framework uses a five-step process known to promote youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors across the lifespan. The five-steps are: (1) profiling needs and response capacity; (2) mobilizing and building needed capacity; (3) developing a comprehensive strategic plan; (4) implementing evidence-based prevention programs, policies and strategies; and (5) evaluating program effectiveness, sustaining what has worked well.

The Strategic Prevention Framework is grounded in six key principles:

Prevention is an ordered set of steps along a continuum to promote individual, family, and community health, prevent mental and behavioral disorders, support resilience and recovery, and prevent relapse. Prevention activities range from deterring diseases and behaviors that contribute to them, to delaying the onset of disease and mitigating the severity of symptoms, to reducing the related problems in communities. This concept is based on the Institute of Medicine model that recognizes the importance of a whole spectrum of interventions.

Prevention is prevention is prevention. The common components of effective prevention for the individual, family or community within a public health model are the same--whether the focus is on preventing or reducing the effects of cancer, cardiovascular disease, diabetes, substance abuse or mental illness.

Common risk and protective factors exist for many mental health and substance use problems. Good prevention focuses on these common risk factors that can be altered. For example, family conflict, low school readiness, and poor social skills increase the risk for conduct disorders and depression, which in turn increase the risk for adolescent substance abuse, delinquency, and violence. Protective factors such as strong family bonds, social skills, opportunities for school success, and involvement in community activities can foster resilience and mitigate the influence of risk factors.

Resilience is built by developing assets in individuals, families, and communities through evidenced-based health promotion and prevention strategies. For example, youth who have relationships with caring adults, good schools, and safe communities develop optimism, good problem-solving skills, and other assets that enable them to rebound from adversity and go on with life with a sense of mastery, competence, and hope.

Systems of prevention services work better than service silos. Working together, researchers and communities have produced a number of highly effective prevention strategies and programs. Implementing these strategies within a broader system of services increases the likelihood of successful, sustained prevention activities.

Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effective prevention efforts. A Strategic Prevention Framework can make it easier for federal agencies, states, and communities to identify common needs and risk factors, adopt assessment

* Substance Abuse and Mental Health Services Administration (SAMHSA), 2004.

tools to measure and track results, and target outcomes to be achieved.

"Best Practice" Prevention Planning Processes	PREVENTION FRAMEWORK					
		Organize the Commuity to Profile Needs, Including Community Readiness	**Mobilize the Community & Build Capacity to Address Needs**	**Develop Prevention Plan (Activities, Programs & Strategies)**	**Implement the Prevention Plan**	**Evaluate for Results & Sustainability**
	Getting to Outcomes (GTO)	Needs and Resources	Capacities Sustain	Goals Best Practices Fit	Planning Implementation	Outcomes Continuous Quality Improvement (CQI)
	Pathways to Effective Programs & Positive Outcomes (Path)	Determine Needs and Resources	Build Capacity	Select/Adapt/Innovate Programs	Implement and Assess Programs	Complete an Evaluation
	Communities that Care (CTC)	Getting Started Developing a Community Profile	Organizing, Introducing, Involving	Creating a Community Action Plan	Implementing and Evaluating the Community Action Plan	Implementing and Evaluating the Community Action Plan
	Western CAPT (WCAPT)	Needs Assessment Resource Assessment	Community Readiness and Mobilization	Prioritizing Focusing Efforts Best Practices	Select and Implement	Evaluation
	Rensselaerville Institute (REN)	Profile community Identify target population Develop outcome statements	Mobilize Investors	Develop performance targets Select product to be offered to customers	Develop product steps, milestones and projections Assess essential elements and advantages Outline intensity and duration Identify key people and outline delivery strategy	Track progress toward milestones using simple verifications Report progress to funding sources quarterly
	Assets Model (Assets)	Develop community-wide profile of developmental assets, risk behaviors and "thriving"	Create cross-sector and intergenerational leadership teams; Build shared vision; Disseminate vision and profile to community	In response to vision and profile, blend community-wide asset-building initiative with prevention programs	Launch, monitor and refine coordinated roll out of prevention programs within a community-wide asset-building initiative	Conduct change-over-time assessments of: Youth assets Youth risk behaviors Community indicators

Moving the framework from vision to practice is a five-step process that stakeholders must undertake supported by leadership and capacity building:

Profile population needs, resources and readiness to address the problems and gaps in service delivery. The health issue confronting the community or state must be assessed accurately through the collection and analysis of epidemiological data. The data should include the magnitude of the problem to be addressed, where the problem is greatest, risk and protective factors associated with the problem, community assets and resources, gaps in services and capacity and readiness to act.

Mobilize and/or build capacity to address needs. Engagement of key stakeholders is crucial to plan and implement successful prevention activities that will be sustained over time. Key tasks include, but are not limited to convening leaders and stakeholders, building coalitions, training community stakeholders and service providers, organizing agency networks, leveraging resources, and engaging stakeholders to help sustain the activities. Working together, stakeholders can develop the necessary social capital to prevent many problems and manage a resilient response to unavoidable adversities.

Develop a comprehensive strategic plan. The strategic plan not only articulates a vision for the prevention activities, it also organizes prevention efforts. Among other elements, it describes key policies and relationships among stakeholders and incentives for public and private service systems to engage in creating a seamless continuum of care. Moreover, it describes the evidence-based programs (or a process for

selection) that will be implemented within the broader service system. Further, the strategic plan identifies key milestones and outcomes against which to gauge performance, herby allowing for system improvement and accountability of all parties involved.

Implement evidence-based, resilience-building prevention programs. Supported by training and technical assistance, local stakeholders select programs proven to be efficacious in research settings and effective in communities. Community implementers work in partnership with program developers to ensure that culturally competent adaptations are made without sacrificing the core elements to the program.

Monitor process, evaluate effectiveness, sustain effective programs, and improve or replace those that fail. Ongoing monitoring and evaluation are essential to determine if the outcomes desired are achieved and to assess program effectiveness and service delivery quality. They also can identify successes and encourage needed improvements to achieve lasing positive results and sustainability. The issue of program sustainability should be a constant throughout each step of planning and program implantation and should lead to the creation of a long-term sustainability strategy.

RISK AND PROTECTIVE FACTORS
RELATED TO SUBSTANCE USE

RISK FACTORS

Risk factors are characteristics of people or their family, school, and community environments that are associated with increases in alcohol, tobacco, marijuana, and other drug use. Seventeen factors have been identified that increase the likelihood that children and youth will develop problem behaviors such as substance abuse.

PROTECTIVE FACTORS

Factors associated with reduced potential for drug use are called protective factors. Protective factors encompass psychological, behavioral, family, and social characteristics that can insulate children and youth from the effects of risk factors that are present in his/her environment.

COMMUNITY

Alcohol and other drugs readily available.
Laws and ordinances are unclear or inconsistently enforced. Norms are unclear or encourage use.
Residents feel little sense of "connection" to community and communities are disorganized.
Neighborhoods have high transitions and residents are very mobile.
Communities have extreme poverty.

Opportunities exist for community involvement.
Laws and ordinances are consistently enforced.
Policies and norms encourage non-use.
Community service opportunities are available for youth.
Resources (housing, healthcare, childcare, jobs, recreation, etc.) are available.

FAMILY

Family member with history of alcohol or other drug abuse.
Parents have trouble keeping track of their teens and do not have clear rules and consequences regarding alcohol and other drug use.
Parents use drugs, involve youth in their use ("get me a beer, would you?") or tolerate use by youth.
Family members have many conflicts.

Close family relationships.
Education is valued and encouraged, and parents are actively involved.
Copes with stress in a positive way.
Clear expectations and limits regarding alcohol and other drug use.
Encourages supportive relationships with caring adults beyond the immediate family.
Shares family responsibilities, including chores and decision-making.
Family members are nurturing and support each other.

SCHOOL

Students lack commitment or sense of belonging at school.
High number of students fail academically at school.
Students exhibit persistent problem behaviors in school.

Communicates high academic and behavioral expectations.
Encourages goal-setting, academic achievement, and positive social development.
Provides leadership and decision-making opportunities for students.
Fosters active involvement of students, parents and community members.
Sponsors substance-free events.

INDIVIDUAL

Youth associates with friends who use.
Has attitude that alcohol and drug use is "cool."
Begins using at a young age.
Has certain physical, emotional or personality traits.
Feels alienated and/or are rebellious.

Involved in alcohol and other drug-free activities.
Views parents, teachers, doctors, law enforcement officers and other adults as allies.
Has positive future plans.
Has friends who disapprove of alcohol and other drug use.

SUBSTANCE ABUSE PREVENTION
GUIDING PRINCIPLES AND BEST PRACTICES

Guiding principles are recommendations on how to create effective prevention programs. When a community already has a prevention program or strategy in place, the guiding principles can be used to gauge the program's potential effectiveness. They can also be used to design an innovative program/strategy when none of the best practices are appropriate to the community's needs.

Best practices are those strategies, activities, or approaches which have been shown through research and evaluation to be effective at preventing and/or delaying substance abuse. Before selecting a best practice or applying the guiding principles, the community must conduct an assessment to identify the risk and protective factors that need to be addressed. Once risk and protective factor(s) to be addressed are identified, the following best practice(s) and/or guiding principles can be used --

"Best practices" are those strategies and programs which have been shown through substantial research and evaluation to be effective at preventing and/or delaying substance abuse and deemed research-based by scientists and researchers of the: National Institute for Drug Abuse (NIDA), Center for Substance Abuse Prevention (CSAP), National Center for the Advancement of Prevention (NCAP), Office of Juvenile Justice and Delinquency Prevention (OJJDP), and Centers for Disease Control and Prevention (CDC).

Science-based prevention. The "scientific method" makes use of strictly defined standardized procedures to determine how events are causally related. As science improves its methods, we benefit with increasing levels of certainty about the nature and extent of cause and effect relationships – we understand better what is required of us in terms of resources and effort to achieve specific outcomes. As we attempt to use the scientific method more systematically to identify knowledge, we also recognize the diversity of the way in which prevention programs are conducted and data extracted.

Science-based actions and programs. Researchers have reviewed numerous studies to determine the effectiveness of programs intended to prevent substance abuse. Best prevention outcomes are achieved by programs which:

- Focus on reducing known risk factors.
- Focus on increasing known protective factors.
- Address risk factors at appropriate developmental stages.
- Intervene early in the youth's life, before negative behavior stabilizes.
- Focus on individuals and communities at greatest risk.
- Address multi-risk issues with multiple strategies, across multiple environments.
- Address cultural and ethnic factors.

Levels of Evidence of Science-Based Practices. A typology was created by the Center for Substance Abuse Prevention (CSAP) to explain how researchers organize prevention programs into a hierarchy or classification scheme. The lower levels (Types 1 and 2) are not considered scientifically defensible but may show some empirical promise. The higher levels (Types 3, 4, and 5) are considered scientifically defensible and demonstrate a more sophisticated level of scientific rigor.

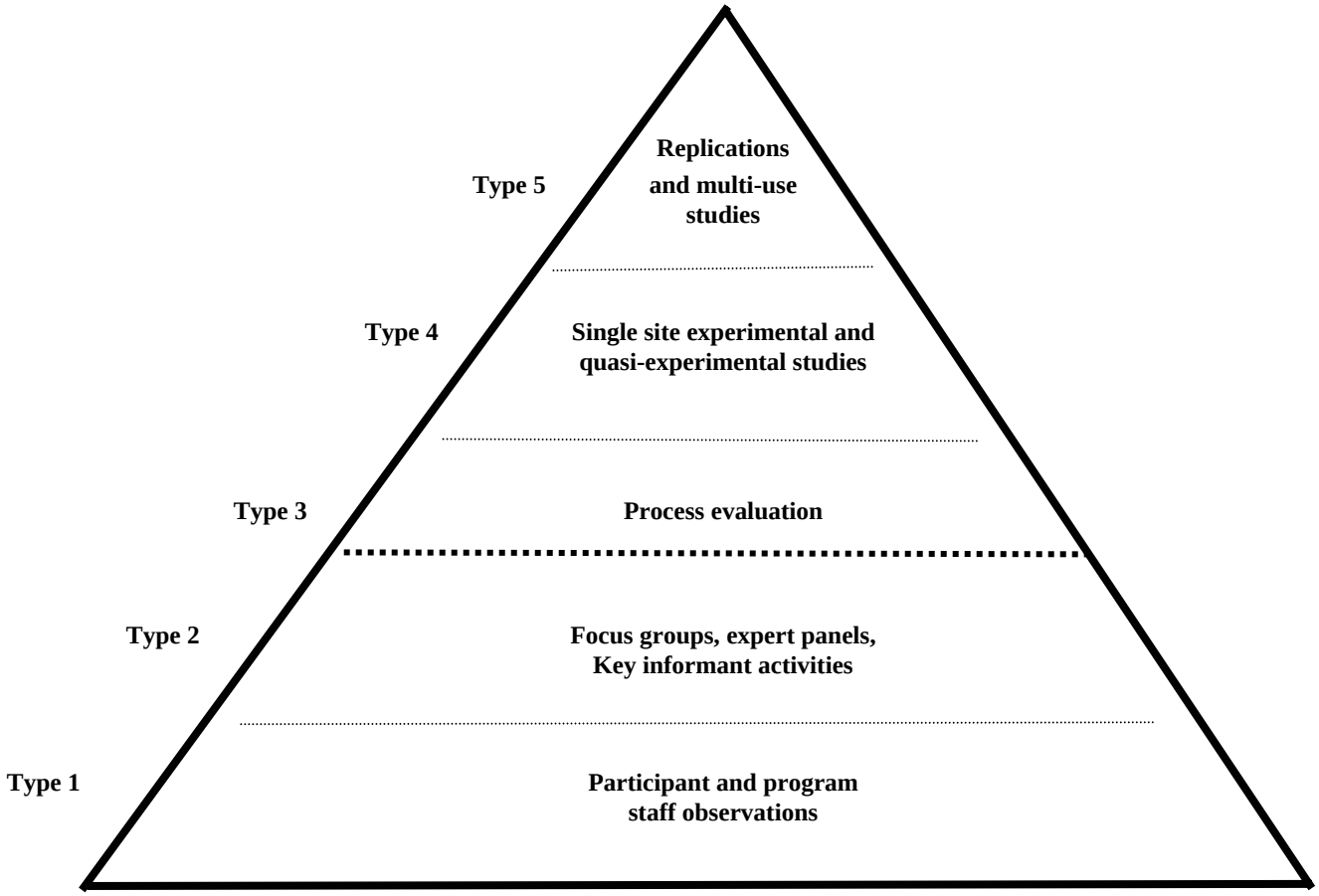
The term "science-based best practices" refers to those strategies, activities, or approaches that have been shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse. "Promising approaches," on the other hand, are programs for which the level of certainty from available evidence is too low to support generalizable conclusions, but for which there is some empirical basis for predicting that further research could support such conclusions.

The following is an overview of the five types of scientific review processes:

> **Type 1.** The program/principle has been identified or recognized publicly, and has received awards, honors, or mentions. This level of recognition is alone insufficient to ensure that principles derived from the strategy, or the model itself, are effective.
>
> **Type 2.** The program/principle has appeared in a nonrefereed professional publication or journal. It is important to distinguish between citations found in professional publications and those found in journals. Appearance in a nonrefereed professional journal generally offers better information about the credibility of the information. Still, the distinction between a nonrefereed and refereed journal is important. Information published in a nonrefereed journal is similar to information in other professional publications and newsletters – it is suggestive, but without substantiation. Refereed journals require that an expert/peer consensus be reached regarding the merit of the work.
>
> **Type 3.** The program's source documents have undergone thorough scrutiny in a expert/peer consensus process for the quality of implementation and evaluation methods, or a paper has appear in a peer-reviewed journal. Unlike journal reviews, complete source documents are scrutinized. All dosage information and data collection processes are detailed; all analyses are presented for review. Reviewers, experienced in the substance abuse prevention field and trained as evaluators, code both the implementation variables and activities, as well as the finding. The project is rated for producing credible information regarding principles of prevention and a summary judgment regarding the potential of the program model for prevention is made.
>
> **Type 4.** The programs/principles have undergone either a quantitative meta-analysis or an expert/peer consensus process in the form of a qualitative meta-analysis. Here, multiple studies are reviewed and coded, generally first for the quality of the methodological rigor and then for findings. Analysis takes place across programs, and principles of prevention are identified. In addition, common activities or prevention strategies that produce consistently positive findings can be enumerated. Because these principles receive support across a broad array of program intervention and evaluation strategies, we gain confidence that the principles are real and solidly defensible. Similarly, because strategies are consistently linked to positive outcomes, we gain confidence that they relate causally to the observed effects.

Type 5. Replications of program/principle have appeared in several refereed professional journals. The best evidence of a program model's effectiveness is that it can be replicated across venues and populations, demonstrating credibility, utility, and generalizability. Programs can be replicated exactly or principles derived from programs can be replicated conceptually. Exact replications simply apply the original program to a new population or in a new venue. Conceptual replications adapt the program, maintaining its key principles but modifying specific activities. Both add to the certainty about the scientific basis of the program. Evidence of replication should be found in refereed journal articles or meta-analytic efforts. Evidence should be unique so that each publication represents a separate program intervention effort. The scientific basis of a program is not strengthened when the same data are published in three different journals, or when different authors all cite the same original study.

There are numerous data collection techniques that are used to gain knowledge in the substance abuse field. The techniques are mapped onto a pyramid in order to reflect proportionately how much information is generated by particular techniques. Ironically, as indicated in the figure, the more sophisticated and traditionally accepted "scientific" approaches represent a small portion of data collection efforts, yet the information derived from such studies comprise a significant portion of the formal knowledge base. Still, it is important to value the diversity of these approaches to learning, as they all can be based on sound scientific principles, and all can add knowledge concerning constructing and implementing successful prevention interventions.



PREVENTION GOALS
(2004-2008)

YOUTH LEADERSHIP DEVELOPMENT	Provide youth with knowledge and leadership skills to implement alcohol and other drug free activities.
PRIMARY PREVENTION PROJECTS FOR YOUTH	Prevent the onset of alcohol, tobacco and other drug use among high-risk youth.
COLLEGE AGE POPULATION	Promote and develop a drug-free lifestyle for the college age population.
ELDERLY PRESCRIPTION ABUSE PREVENTION	Reduce prescription misuse and increase knowledge of the dangers of interactive effects of medicine in the elderly.
NATIVE HAWAIIAN AGRICULTURAL PROJECT	Promote culturally rich Native Hawaiian prevention education and wholesome lifestyle role modeling to elementary grade children.
NATIVE HAWAIIAN EX-OFFENDER PREVENTION PROGRAM	Improve the quality of life of Native Hawaiian ex-offenders by incorporating a substance abuse prevention project that employs traditional Native Hawaiian healing methods.
STATE RESOURCE CENTER (RADAR)	Assure a statewide reservoir of current alcohol, tobacco and other drug information and the availability of the most current information on substance abuse prevention and treatment services.
TARGETED EDUCATION/ PREVENTION	Increase professional and public awareness of the health and safety risks associated with the use and abuse of alcohol and other drugs.
PUBLIC AWARENESS CAMPAIGN	Promote a wellness model to influence the behaviors and attitudes of the public regarding alcohol and other drugs.
UNDERAGE DRINKING	Increase awareness of the underage drinking problem to prevent early onset drinking.